CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	

CLINICAL INFORMATION

Medication requested:

Preferred Medication:

- ☐ Adalimumab-aacf 50 mg/ml Pen
- ☐ Adalimumab-aacf 50 mg/ml Syringe
- ☐ Adalimumab-adaz(CF) 100 mg/ml Pen
- ☐ Adalimumab-adaz(CF) 100 mg/ml Syringe
- ☐ Adalimumab-adbm(CF) 50 mg/ml Pen (Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 50 mg/ml Syringe (Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 100 mg/ml Pen (Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 100 mg/ml Syringe (Boehringer Ingelheim)
- ☐ Adalimumab-fkjp(CF) 50 mg/ml Pen
- ☐ Adalimumab-fkjp(CF) 50 mg/ml Syringe
- ☐ Amjevita(CF) (adalimumab-atto) 100 mg/ml Autoinjector
- ☐ Amjevita(CF) (adalimumab-atto) 100 mg/ml Syringe
- ☐ Avsola (infliximab-axxq) Vial
- ☐ Enbrel (etanercept) Mini Cartridge
- ☐ Enbrel (etanercept) Sureclick Pen
- ☐ Enbrel (etanercept) Syringe
- ☐ Enbrel (etanercept) Vial
- ☐ Hadlima (adalimumab-bwwd) 50 mg/ml Pushtouch
- ☐ Hadlima (adalimumab-bwwd) 50 mg/ml Syringe
- ☐ Hadlima(CF) (adalimumab-bwwd) 100 mg/ml Pushtouch
- ☐ Hadlima(CF) (adalimumab-bwwd) 100 mg/ml Syringe
- ☐ Humira (adalimumab) 50 mg/ml Pen
- ☐ Humira (adalimumab) 50 mg/ml Syringe
- ☐ Humira(CF) (adalimumab) 100 mg/ml Pen
- ☐ Humira(CF) (adalimumab) 100 mg/ml Syringe
- ☐ Infliximab Vial (Janssen's unbranded infliximab)
- ☐ Kineret (anakinra) Syringe
- ☐ Orencia (abatacept) Clickjet
- ☐ Orencia (abatacept) Vial
- ☐ Otezla (apremilast) Tablet
- ☐ Simlandi(CF) (adalimumab-ryvk) 100 mg/ml Autoinjector
- ☐ Simponi (golimumab) Pen
- ☐ Simponi (golimumab) Syringe
- ☐ Skyrizi (risankizumab-rzaa) On-Body Injector
- ☐ Skyrizi (risankizumab-rzaa) Pen
- ☐ Skyrizi (risankizumab-rzaa) Syringe
- ☐ Skyrizi (risankizumab-rzaa) Vial
- ☐ Taltz (ixekizumab) Autoinjector
- ☐ Taltz (ixekizumab) Syringe
- ☐ Tyenne (tocilizumab-aazg) Autoinjector
- ☐ Tyenne (tocilizumab-aazg) Syringe
- ☐ Tyenne (tocilizumab-aazg) Vial
- ☐ Xeljanz (tofacitinib) Solution
- ☐ Xeljanz (tofacitinib) Tablet
- ☐ Xeljanz XR (tofacitinib) Tablet
- ☐ Yusimry(CF) (adalimumab-aqvh) 50 mg/ml Pen

Medication requested:

Non-Preferred Medication:

- ☐ Abrilada(CF) (adalimumab-afzb) 50 mg/ml Pen
- ☐ Abrilada(CF) (adalimumab-afzb) 50 mg/ml Syringe
- ☐ Actemra (tocilizumab) Actpen
- ☐ Actemra (tocilizumab) Syringe
- ☐ Actemra (tocilizumab) Vial
- ☐ Adalimumab-aaty(CF) 100 mg/ml Autoinjector
- ☐ Adalimumab-aaty(CF) 100 mg/ml Syringe
- ☐ Adalimumab-adbm(CF) 50 mg/ml Pen (all labelers except Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 50 mg/ml Syringe (all labelers except Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 100 mg/ml Pen (all labelers except Boehringer Ingelheim)
- ☐ Adalimumab-adbm(CF) 100 mg/ml Syringe (all labelers except Boehringer Ingelheim)
- ☐ Adalimumab-ryvk(CF) 100 mg/ml Autoinjector
- ☐ Adalimumab-ryvk(CF) 100 mg/ml Syringe
- ☐ Amjevita(CF) (adalimumab-atto) 50 mg/ml Autoinjector
- ☐ Amjevita(CF) (adalimumab-atto) 50 mg/ml Syringe
- ☐ Arcalyst (rilonacept) Vial
- ☐ Bimzelx (bimekizumab-bkzx) Autoinjector
- ☐ Bimzelx (bimekizumab-bkzx) Syringe
- ☐ Cimzia (certolizumab pegol) Syringe
- ☐ Cosentyx (secukinumab) Sensoready Pen
- ☐ Cosentyx (secukinumab) Syringe
- ☐ Cosentyx (secukinumab) Unoready Pen
- ☐ Cosentyx (secukinumab) Vial
- ☐ Cyltezo(CF) (adalimumab-adbm) 50 mg/ml Pen
- ☐ Cyltezo(CF) (adalimumab-adbm) 50 mg/ml Syringe
- ☐ Cyltezo(CF) (adalimumab-adbm) 100 mg/ml Pen
- ☐ Cyltezo(CF) (adalimumab-adbm) 100 mg/ml Syringe
- ☐ Entyvio (vedolizumab) Pen
- ☐ Entyvio (vedolizumab) Vial
- ☐ Hulio(CF) (adalimumab-fkjp) 50 mg/ml Pen
- ☐ Hulio(CF) (adalimumab-fkjp) 50 mg/ml Syringe
- ☐ Hyrimoz(CF) (adalimumab-adaz) 100 mg/ml Pen
- ☐ Hyrimoz(CF) (adalimumab-adaz) 100 mg/ml Syringe
- ☐ Idacio(CF) (adalimumab-aacf) 50 mg/ml Pen
- ☐ Idacio(CF) (adalimumab-aacf) 50 mg/ml Syringe
- ☐ Ilaris (canakinumab) Vial
- ☐ Ilumya (tildrakizumab) Syringe
- ☐ Inflectra (infliximab-dyyb) Vial
- ☐ Kevzara (sarilumab) Pen
- ☐ Kevzara (sarilumab) Syringe
- ☐ Litfulo (ritlecitinib) Capsule
- ☐ Olumiant (baricitinib) Tablet
- ☐ Omvoh (mirikizumab-mrkz) Pen
- ☐ Omvoh (mirikizumab-mrkz) Syringe
- ☐ Omvoh (mirikizumab-mrkz) Vial
- ☐ Orencia (abatacept) Syringe
- ☐ Remicade (infliximab) Vial
- ☐ Renflexis (infliximab-abda) Vial
- ☐ Rinvoq ER (upadacitinib) Tablet
- ☐ Rinvoq LQ (upadacitinib) Solution
- ☐ Siliq (brodalumab) Syringe
- ☐ Simponi Aria (golimumab) Vial
- ☐ Sotyktu (deucravacitinib) Tablet
- ☐ Spevigo (spesolimab-sbzo) Syringe
- ☐ Spevigo (spesolimab-sbzo) Vial
- ☐ Stelara (ustekinumab) Syringe
- ☐ Stelara (ustekinumab) Vial
- ☐ Tofidence (tocilizumab-bavi) Vial
- ☐ Tremfya (guselkumab) Autoinjector
- ☐ Tremfya (guselkumab) Syringe
- ☐ Yuflyma(CF) (adalimumab-aaty) 100 mg/ml Autoinjector
- ☐ Yuflyma(CF) (adalimumab-aaty) 100 mg/ml Syringe
- ☐ Zymfentra (infliximab-dyyb) Pen
- ☐ Zymfentra (infliximab-dyyb) Syringe

CLINICAL INFORMATION

STARTER PACK requested (strength/formulation):		MAINTENANCE product/packaging requested (strength/formulation):	
Quantity per fill:	Refills:	Quantity per fill:	Refills:
Directions:		Directions:	
Diagnosis *(submit documentation):*		Dx code (required):	Beneficiary weight:
Is the beneficiary currently being treated with the requested medication?		☐ Yes – date of last dose: _____ *Submit documentation.* ☐ No	
Is the requested medication prescribed by or in consultation with a specialist (e.g., rheumatologist, dermatologist, gastroenterologist, etc)?		☐ Yes ☐ No *If prescriber is not a specialist, submit documentation of consultation.*	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
NPI#:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL REQUESTS

Drug

1. **Requested drug is NON-PREFERRED:**
   ☐ Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition.
   List preferred medications tried: _____
2. **Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):**
   ☐ Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder
3. **Requested drug is an oral JAK inhibitor (eg, Olumiant [baricitinib],Rinvoq [upadacitinib], Xeljanz [tofacitinib]):**
   ☐ Tried and failed at least one TNF blocker or another biologic as recommended in the JAK inhibitor's package labeling
   ☐ Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package labeling

Diagnosis

1. **ALL diagnoses:**
   ☐ Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody) (if recommended in the FDA-approved package labeling)
   ☐ Screened for tuberculosis (if recommended in the FDA-approved package labeling)
2. **Adult-onset Still's disease:**
   ☐ Has predominantly systemic disease:
   ☐ Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist
   ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   ☐ Has predominantly joint disease:
   ☐ Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)
3. **Alopecia areata:**
   ☐ Has alopecia universalis
   ☐ Has >50% scalp involvement or alopecia totalis
   ☐ Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning
   ☐ Has a current episode of alopecia areata that has lasted at least 6 months
4. **Ankylosing spondylitis & non-radiographic axial spondyloarthritis:**
   ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs
5. **Behçet's syndrome:**
   ☐ Has a diagnosis of Behçet's syndrome according to current consensus guidelines
   ☐ Has recurrent oral ulcers associated with Behçet's syndrome
   ☐ Tried and failed or has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental paste)
   ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to colchicine at maximally tolerated doses
6. **Crohn's disease:**
   ☐ Has moderate-to-severe disease
   ☐ Has disease that is associated with high-risk or poor prognostic features
   ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
   ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (e.g., AZA, 6-MP, MTX)
7. **Familial Mediterranean fever:**
   ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to colchicine at maximally tolerated doses

INITIAL REQUESTS (continued)

8. Generalized pustular psoriasis (GPP) flares:
- ☐ Request is for Spevigo (spesolimab) intravenous:
  - ☐ Is being treated for a GPP flare
  - ☐ One of the following:
    - ☐ Beneficiary has received a single dose of spesolimab for the current GPP flare AND:
      - ☐ Continues to experience moderate to severe GPP flare symptoms since the previous dose
    - ☐ Beneficiary has not received a dose of spesolimab for the current GPP flare AND:
      - ☐ Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement
- ☐ Request is for Spevigo (spesolimab) subcutaneous:
  - ☐ Has a history of at least one GPP flare
  - ☐ Is using subcutaneous spesolimab for the prevention of GPP flares

9. Giant cell arteritis:
- ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Is at high risk for glucocorticoid-related complications
- ☐ Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist

10. Gout flare:
- ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to NSAIDs
- ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to colchicine
- ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to corticosteroids
- ☐ Has a medical reason why repeated courses of corticosteroids are not appropriate

11. Hidradenitis suppurativa (HS):
- ☐ Has Hurley stage II or stage III disease
- ☐ Is a candidate for or has a history of surgical intervention for HS
- ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin
- ☐ Tried and failed or has a contraindication or an intolerance to systemic antibiotics (e.g., doxycycline, minocycline, tetracycline, clindamycin)

12. Juvenile idiopathic arthritis:
- ☐ Has systemic disease with active systemic features
- ☐ Has disease associated with any of the following:
  - ☐ Positive anti-CCP antibodies
  - ☐ Positive rheumatoid factor
  - ☐ Presence of joint damage
  - ☐ At high risk of disabling joint damage
  - ☐ High disease activity
  - ☐ Involvement of high-risk joints (cervical spine, hip, wrist)
- ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., MTX)
- ☐ Has active sacroiliitis and/or enthesitis:
  - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to oral NSAIDs

13. Plaque psoriasis:
- ☐ Has a BSA of ≥3% that is affected
- ☐ Has involvement of critical areas of the body (eg, skin folds, face, genitals)
- ☐ Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
- ☐ Has moderate-to-severe nail disease
- ☐ Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids
- ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (e.g., anthralin, calcineurin inhibitor, tazarotene, etc)

14. Polymyalgia rheumatica:
- ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist

15. Psoriatic arthritis:
- ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., AZA, leflunomide, MTX, SSZ)
- ☐ Has predominantly axial disease, dactylitis, and/or enthesitis
- ☐ Has severe disease
- ☐ Has comorbid moderate-to-severe nail psoriasis
- ☐ Has comorbid active inflammatory bowel disease

16. Rheumatoid arthritis:
- ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., AZA, leflunomide, MTX, etc.)

17. Sarcoidosis:
- ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Has steroid-dependent disease
- ☐ Tried and failed or has a contraindication or an intolerance to a conventional DMARD (e.g., AZA, leflunomide, MTX, mycophenolate)

INITIAL REQUESTS (continued)

18. Ulcerative colitis:
- ☐ Has moderate-to-severe disease
- ☐ Has disease associated with multiple poor prognostic factors
- ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
- ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (e.g., AZA, cyclosporine, 6-MP, MTX)

19. Uveitis (non-infectious):
- ☐ Has comorbid juvenile idiopathic arthritis
- ☐ Has comorbid Behçet's syndrome
- ☐ Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist
- ☐ Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids
- ☐ Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (e.g., AZA, MTX, MMF, etc.)

20. Other diagnosis:
- ☐ List other treatments tried (including start/stop dates, dose, outcomes):

RENEWAL REQUESTS

- ☐ Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication
- ☐ Is prescribed an increased dose or more frequent administration of the requested medication that is supported by peer-reviewed medical literature or national treatment guidelines
- ☐ **Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):**
  - ☐ Was recently reevaluated for behavioral and mood changes

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: